Appendix 7
Prior Authorization Request Form Completion Instructions

Element 1 — Processing Type
Enter the appropriate three-digit processing type from the list below. The "processing type" is a three-digit code used to identify a category of service requested.

131 — Drugs, Enteral Nutrition Products.
137 — 24-Hour Drug.
637 — Wisconsin Specialized Transmission Approval Technology — Prior Authorization (STAT-PA).

Element 2 — Recipient's Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification (ID) number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient's Address
Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing facility, also include the name of the nursing facility.

Element 5 — Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., June 18, 1942 would be 07/18/1942).

Element 6 — Sex
Enter an "X" to specify male or female.

Element 7 — Billing Provider's Name, Address, and ZIP Code
Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Element 8 — Billing Provider's Telephone Number
Enter the billing provider's telephone number, including the area code of the office, clinic, facility, or place of business.

Element 9 — Billing Provider's Wisconsin Medicaid Provider Number
Enter the billing provider's eight-digit Medicaid provider number.

Element 10 — Dx: Primary
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested for the recipient.

Note: Pharmacists need only provide a written description.

Element 11 — Dx: Secondary
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Note: Pharmacists need only provide a written description.

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code(s)
Enter the appropriate 11-digit National Drug Code (NDC) or Wisconsin Medicaid-assigned 5-digit procedure code for each service/procedure/item requested. For Enteral Nutrition Products, enter the appropriate HCFA Common Procedure Coding System (HCPCS) code.

Note: Leave this element blank for HealthCheck "Other Services."

Element 15 — MOD
Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medicaid policy and the coding structure used) for each service/procedure/item requested.

Element 16 — POS
Enter the appropriate Medicaid single-digit place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Pharmacy
3	Doctor's Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

Element 17 — TOS
Enter the appropriate Medicaid single-digit type of service (TOS) code for each service/procedure/item requested.

TOS Code	Description
D	Drugs

Element 18 — Description of Service
Enter a written description corresponding to the appropriate 11-digit NDC, 5-digit procedure code, or 3-digit revenue code for each service/procedure/item requested.

Note: When resubmitting a STAT-PA claim, reference the STAT-PA number in the description field on the Prior Authorization Request Form (PA/RF).

Element 19 — Quantity of Service Requested
Enter the quantity (e.g., number of units, dollar amount) requested for each service/procedure/item requested.

- Drugs — number of units or days' supply.

Element 20 — Charges
Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Social Service's *Terms of Provider Reimbursement*.

Element 21 — Total Charge
Enter the anticipated total charge for this request.

Element 22 — Billing Claim Payment Clarification Statement
An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid methodology and policy. If the recipient is enrolled in a commercial managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the commercial managed care program and PA has been obtained.

Element 23 — Date
Enter the month, day, and year (in MM/DD/YYYY format) the PA/RF was completed and signed.

Element 24 — Requesting Provider's Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY WISCONSIN MEDICAID CONSULTANTS AND ANALYSTS.